Application and Instructions for EMT Training Program

NOTE: Please submit a separate application for each training program to be conducted.

SELECT ONE OF THE FOLLOWING:

- ☐ **EMT-Basic Training Program**
- ☐ **EMT-Cardiac Training Program**
- ☐ **EMT-Paramedic Training Program**
- ☐ **Orotracheal/Endotracheal Intubation Course**
- ☐ **IV Nitroglycerin Course**
- ☐ **IV Anticoagulant Therapy Course**
  Specify Anticoagulants _____
- ☐ **EMT Refresher Program**
  __ **Basic** __ **Basic/Cardiac** __ **Paramedic**

DOH USE ONLY

Start _____ End _____ I/C _____
Sponsor _____ ☐ Public Tel _____
☐ Complete Date _____ Initials _____ Appv # _____

Division of EMS 3 Capitol Hill, Providence, RI 02908-5097 Tel (401)222-2401 Fax (401)222-5322

INSTRUCTIONS

Submit completed application and affidavit to:

Rhode Island Department of Health
Division of Emergency Medical Services
Three Capitol Hill
Room 105
Providence, RI 02908-5097

This application must be submitted to the Division of Emergency Medical Services a minimum of 30 days prior to the start of the program.

Instructor-coordinators should ensure that all training aids and equipment needed to assure compliance with the course objectives and operations are reserved with the appropriate officials prior to the start of the training program.

If you have any questions concerning this application, call the Department of Health, Division of Emergency Medical Services at (401) 222-2401.

State of Rhode Island and Providence Plantations
Department of Health
Division of Emergency Medical Services

Instructor-Coordinator: Please provide the name, RI license number and mailing information of the licensed EMS instructor-coordinator responsible for this program.	Name:_____ RI License Number_____ Address Line 1:_____ Address Line 2:_____ Address Line 3:_____ City, State, Zip Code_____ Phone: _____ Fax: _____ Email Address:_____
Sponsoring Agency: (If applicable) Please provide the name of the sponsoring agency.	Name: _____ Address Line 1:_____ Address Line 2:_____ Address Line 3:_____ City, State, Zip Code_____ Phone: _____ Fax:_____ Email Address: _____
Course/Training Facility Location Information: Please provide the location information for this facility.	Name:_____ Address Line 1:_____ Address Line 2:_____ Address Line 3:_____ City, State, Zip Code_____
Course Physician Medical Director: Please provide the name, RI license number and telephone number of the physician medical director concerning this program.	Name:_____ RI License Number_____ Phone Number: ( )_____

Course Dates: Please provide the dates that this program will be taking place.	From: _____/_____/_____ To: _____/_____/_____
Student Enrollment:	Please list the approximate number of students to be enrolled in this program. ☐☐
Textbook(s):	Please list the textbook(s) to be used for this program. _____ _____
Public Course:	Is this course open to the public? Yes ☐ No ☐ If yes, please list the contact phone number for the public:_____
Equipment/Training Resources:	Please provide the following: A list of the **training resources** and a **detailed list of equipment** (including type and number available) that will be used during this training program. _____ _____ _____ _____ _____

EMS INSTRUCTOR - COORDINATOR AFFIDAVIT

SELECT ONE OF THE FOLLOWING:

☐ **EMT-Basic Training Program**

☐ **EMT-Cardiac Training Program**

☐ **EMT-Paramedic Training Program**

☐ **Orotracheal/Endotracheal Intubation Course**

☐ **IV Nitroglycerin Course**

☐ **IV Anticoagulant Therapy Course**

Specify Anticoagulants _____

☐ **EMT Refresher Program**

__ **Basic** __ **Basic/Cardiac** __ **Paramedic**

I hereby certify that I, the EMS licensed instructor-coordinator, have completed and submitted all pages of this application to conduct the EMT training program referenced above and that this application represents a true and accurate record of the training program to be conducted. I certify and attest that this course meets the content requirements of the Department of Health approved edition of the US Department of Transportation, National Highway Traffic Safety Administration EMT National Standard Curriculum, as applicable, and I further attest that the conduct of the course referenced above will adhere to all applicable Rhode Island Department of Health, Division of Emergency Medical Services, Rules and Regulations Relating to Emergency Medical Services (R23-4.1-EMS) and Course Guideline Manual Requirements.

I understand that the Department of Health will conduct an audit of EMT Training Programs in compliance with the Rules and Regulations Relating to Emergency Medical Services (R23-4.1-EMS) and/or Department of Health Course Guideline Requirements. Such audits, as randomly selected, shall require the EMS instructor-coordinator to file proof of completion of the EMT training program in compliance with the Department requirements to include the submission of all training-related records of course management as deemed necessary by the Department. False/incorrect statements or documents may be considered sufficient cause to deny or revoke a license as an EMS Instructor Coordinator in Rhode Island and may include revocation of the course approval. This may also result in additional penalties as determined by law.

_____ _____

Signature of Instructor/Coordinator **Date**

NOTARY PUBLIC

Signed and subscribed to before me this _____day of _____20___. **NOTARY SEAL**

_____ _____

Signature of Notary Public **My Commission Expires**

NOTE: Application does NOT need to be notarized if delivered to the Division of EMS office in person by the Instructor/Coordinator.